IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

BERNICE L. WRIGHT,

Plaintiff,

CV 07-47-ST

v.

MICHAEL J. ASTRUE, Commissioner of Social Security,

FINDINGS AND RECOMMENDATION

Defendant.

STEWART, Magistrate Judge:

INTRODUCTION

Plaintiff, Bernice Wright, brings this action for judicial review of a final decision of the Commissioner of Social Security denying her application for disability insurance benefits ("DIB") under Title II of the Social Security Act. The court has jurisdiction under 42 USC § 405(g). The Commissioner concedes that his decision contains errors and moves the court to remand for further proceedings (docket #24). Wright opposes additional proceedings and seeks an immediate award of benefits. The Commissioner's motion to remand for further proceedings

should be denied, and the Commissioner's final decision should be reversed and remanded for an award of benefits.

BACKGROUND

Wright is now 58 years old. Tr. 97.[1] She graduated from college and has a master's degree. Tr. 878. Wright worked as a medical technologist from 1975 to 2002. Tr. 144. She alleges disability from January 12, 2002, her last day of work, due to a combination of neurological, sensorimotor, and vestibular impairments resulting in gait disturbance, weakness, unsteadiness, and pain. Wright filed for DIB on August 30, 2002, and her application was denied initially and on reconsideration. Hearings were held before an Administrative Law Judge ("ALJ") on July 7, 2005 and March 10, 2006. Tr. 866-936. The ALJ found that Wright satisfied the insured status requirements for a claim under Title II through December 31, 2007. Tr. 14. Thus, Wright must establish that she was disabled on or before that date to prevail on her DIB claim. 42 USC § 423(a)(1)(A); *Tidwell v. Apfel,* 161 F3d 599, 601 (9th Cir 1998). The ALJ issued an opinion on April 10, 2006, finding Wright was not disabled. Tr. 14-25. The Appeals Council then denied review (Tr. 2-5), making the ALJ's decision the final decision of the Commissioner.

DISABILITY ANALYSIS

The initial burden of proof rests upon the claimant to establish disability. *Roberts v. Shalala*, 66 F3d 179, 182 (9th Cir 1995). To meet this burden, a claimant must demonstrate an "inability to engage in any substantial gainful activity by reason of any medically determinable

[1] Citations to "Tr." refer to the page(s) indicated in the official transcript of the administrative record filed with the Commissioner's Answer .

physical or mental impairment which can be expected . . . to last for a continuous period of not less than 12 months." 42 USC § 423(d)(1)(A).

The Commissioner has established a five-step sequential process for determining whether a person is disabled within the meaning of the Act. *Bowen v. Yuckert*, 482 US 137, 140 (1987); 20 CFR § 404.1520. At step one, the claimant is not disabled if the Commissioner determines that the claimant is engaged in substantial gainful activity ("SGA"). *Bowen v. Yuckert,* 482 US at 140; 20 CFR § 404.1520(b).

At step two, the Commissioner determines whether the claimant has a medically severe impairment or combination of impairments. An impairment is severe if it significantly limits the claimant's ability to perform basic work activities. 20 CFR § 404.1521. Basic work activities are the abilities and aptitudes necessary to do most jobs. *Id.* The burden to show a medically determinable severe impairment is on the claimant. *Bowen,* 482 US at 146.

At step three, the claimant is found disabled if her impairments meet the duration requirement and meet or equal "one of a number of listed impairments that the [Commissioner] acknowledges are so severe as to preclude substantial gainful activity." *Id* at 141; 20 CFR § 404.1520(d). The criteria for these listed impairments are enumerated in 20 CFR Pt. 404, subpt. P, app. 1 ("Listing").

If the adjudication proceeds beyond step three, the Commissioner must assess the claimant's residual functional capacity ("RFC"). The claimant's RFC is an assessment of the sustained work-related activities the claimant can still do on a regular and continuing basis, despite the limitations imposed by her impairments. 20 CFR § 404.1545(a); Social Security Ruling ("SSR") 96-8p, 1996 WL 374184 (July 2, 1996).

At step four, the Commissioner must determine whether the claimant retains the RFC to perform work she has done in the past. If she does, the Commissioner will find the claimant not disabled. 20 CFR § 404.1520(f).

If the adjudication reaches step five, the Commissioner must determine whether the claimant can perform any work that exists in the national economy. *Bowen,* 482 US at 142; 20 CFR § 404.1520(g). Here the burden of production shifts to the Commissioner to show that a significant number of jobs exist in the national economy that the claimant can perform. *Tackett v. Apfel*, 180 F3d 1094, 1099 (9th Cir 1999). If the Commissioner meets this burden, then the claimant is not disabled. 20 CFR § 404.1566.

THE ALJ's FINDINGS

At step one, the ALJ found Wright had not engaged in substantial gainful activity at any time since her alleged onset of disability. Tr. 16.

At step two, the ALJ determined that Wright has the severe impairment of mild degenerative disc disease, status post laminectomy at L4-L5. *Id.*

At step three, the ALJ found that Wright's impairments did not meet or medically equal the criteria for a listing. Tr. 18.

The ALJ determined that Wright retained the RFC to perform light level work and stand, walk, or sit for six hours out of an eight-hour day. Tr. 18. He limited her to occasional crouching, bending, and climbing stairs. *Id.* A vocational expert ("VE") testified at the hearing that Wright's past relevant work was at a light level of exertion. Tr. 934. The VE testified that given Wright's age, education, experience, and RFC, she could perform her past relevant work. Tr. 934-35. At step four, the ALJ adopted the testimony of the VE that Wright could perform

her past relevant work and was not disabled within the meaning of the Social Security Act. Tr. 24-25.

STANDARD OF REVIEW

The district court must affirm the Commissioner's decision if it is based on proper legal standards and the findings are supported by substantial evidence in the record as a whole. 42 USC § 405(g); *Batson v. Comm'r of Soc. Security Admin.,* 359 F3d 1190, 1193 (9th Cir 2004). "Substantial evidence means . . . such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Andrews v. Shalala*, 53 F3d 1035, 1039 (9th Cir 1995).

The ALJ is responsible for determining credibility and resolving conflicts in the medical evidence. *Edlund v. Massanari,* 253 F3d 1152, 1156 (9th Cir 2001) (citations omitted). The court must weigh all of the evidence, whether it supports or detracts from the Commissioner's decision. *Martinez v. Heckler*, 807 F2d 771, 772 (9th Cir 1986). If the evidence can reasonably support either affirming or reversing the Commissioner's conclusion, the court may not substitute its judgment for that of the Commissioner. *Batson,* 359 F3d at 1193.

DISCUSSION

Wright asserts that the ALJ erred by failing to find some of her impairments severe at step two of the sequential analysis. She also alleges the ALJ failed to properly credit the opinion of her treating physicians and specialists and erred in assessing her credibility. The Commissioner concedes that the ALJ improperly evaluated the opinions of Drs. Brown, Gancher, Dellinger and Jones, and seeks a remand for the ALJ to reconsider these medical source opinions. Wright asserts no issues remain unresolved and that properly crediting these opinions and her testimony establishes her disability.

I. Medical Background

Wright was diagnosed with epilepsy as a child and took prescribed anti-seizure medications for much of her life, including Mysoline and Dilantin. Tr. 285. She experienced chronic low back pain since 1983 which resulted in a L4-L5 laminectomy in 1991. *Id.* Wright worked full time until 1999 when she began experiencing more back pain. Tr. 323. From August 2001 through March 2002, Brett R. Stacey, M.D., and David V. Nelson, Ph.D., treated Wright at the Oregon Health Sciences University ("OHSU") Pain Management Center. Tr. 292-333. They diagnosed and treated Wright for chronic low back pain, status post laminectomy, degenerative disc disease ("DDD"), sleep disturbance, major depressive disorder, post traumatic stress disorder, and chronic pain disorder associated with both physical factors and psychological factors. Tr. 324-32. Wright reduced her pain levels by using a back brace, attending physical therapy ("PT"), receiving counseling, and undergoing relaxation therapy. She also reduced her work schedule, used some work modifications, and took Desipramine. Tr. 301-03, 314.

Although Wright noted intermittent periods of weakness since 1999, she experienced an acute onset of weakness in January 2002. Tr. 297-98. On February 7, 2002, Dr. Stacey, of the Pain Management Center, opined the weakness could be a "non-adaptative response to an increase in muscle pain associated with [PT]" or a symptom of depression. Tr. 295. He advised Wright that it was her volitional choice to stay in bed and she should continue Desipramine and follow up with her family doctor. Tr. 295-96. A week later on February 14, 2002, Wright was

admitted to the hospital due to orthostatic hypotension,[2] secondary to Desipramine therapy. Tr. 209. She was advised to wean off Desipramine. *Id.*

Dr. Matthew Zukowski, a neurologist, evaluated Wright in March 2002. Tr. 374-79. He noted that her brain MRI showed some demyelinating processes which can be associated with various changes. Tr. 374-75. He further noted a slight peripheral neuropathy involving the bilateral lower extremities, slightly wide-based gait, and poor vibratory and proprioceptive sense in her feet. Tr. 376-77. Her exam was otherwise normal. Dr. Zukowski was concerned about low levels of vitamin B12 and prescribed supplements. Tr. 373-74. He referred her to Dr. Gregory L. Clark for a second opinion. Tr. 265.

Dr. Clark examined Wright in April 2002. Tr. 550-53. He opined that the vitamin B12 deficiency was consistent with posterior column dysfunction as evidenced by decreased vibratory and proprioceptive sense. Tr. 552. He further noted her spinal problems contributed to her mild balance and weakness problems. *Id.* However, he concluded that her intermittent weakness was most likely not a neurological problem, but was due to reflex inhibition of strength due to muscle spasm, and her numbness and tingling was due to myofascial overlay. *Id.* Dr. Clark further noted that the anti-seizure medication Mysoline depletes folate and recommended vitamin B12 supplements to prevent further deterioration. Tr. 553. He added that Wright's vitamin B12 deficiency could result in mild chronic balance disturbance "indefinitely." *Id.*

[2] Orthostatic hypotension is low blood pressure, or a sudden drop in blood pressure. One of the symptoms of orthostatic hypotension is weakness. Certain medications can cause on onset of orthostatic hypotension. Orthostatic Hypotension, www.mayoclinic.com/health/orthostatic-hypotension/DS0097. Last viewed March 26, 2008.

For the next three years, Wright continued to seek treatment and diagnosis for her unusual symptomology from providers at Kaiser and OHSU. She was referred to clinics in physiatry, neurology, rheumatology, orthopedics, psychology, internal medicine, and movement disorder. She was diagnosed at various times with gait disturbance due to posterior column dysfunction from B12 deficiency (Tr. 259), muscle weakness (Tr. 260), low phosphorous (Tr. 424-25), reaction to anti-seizure medication (Tr. 207, 428), decreased vibratory sense and proprioception in bilateral feet (Tr. 428, 457), DDD in lumber and cervical spine (Tr. 433), broad based central disc bulge at C6-C7 causing mild to moderate stenosis of central spinal canal (Tr. 222), probable somatization disorder (Tr. 585, 640), myofascial pain syndrome (Tr. 640), intermittent weakness due to reflex inhibition of strength due to muscle spasm (Tr. 641), slight right-sided cord flattening at T6-T7 due to posterior marginal osteophyte formation, mild left foraminal narrowing at T2-T3 due to facet hypertrophy (Tr. 450), adjustment disorder with mixed emotional features (Tr. 443), length dependent mild sensory motor neuropathy and chronic low back pain (Tr. 707), chronic pain syndrome (Tr. 642), sensory polyneuropathy of feet (Tr. 713), post traumatic abnormal uptake in the ribs bilaterally and at L2-L3 spinous processes, and degenerative facet disease at L4-L5, L5-SI (Tr. 622), depression, (Tr. 716), impingement and bruising of spinal cord at the time of fall she suffered in late 2001, resulting in intermittent transmission problems through the cervical cord (Tr. 562), hypochondriasis (Tr. 761), sensorimotor axonal neuropathy (Tr. 629), and conversion disorder (Tr. 761).

Wright's treating physician and neurologists discussed her functional limitations. Her primary care physician at Kaiser, R. Stephen Jones, M.D., wrote a letter on March 7, 2003, noting that Wright was under his care for disabling back pain and weakness. Tr. 468. He stated

that Wright has been unable to sit or stand more than 15 minutes for more than the past 12 months, which would likely persist for another 12 months or longer. *Id.* On July 14, 2003, Dr. Jones wrote another letter citing Wright's most recent bone scans with SPECT imaging which showed abnormal uptake in the ribs and lumbar spinous processes and degenerative facet disease. Tr. 622. He opined that she had chronic pain, inability to stand for any length of time, and was disabled for at least 12 months. *Id.*

In January 2004, Dr. Stephen Gancher, Wright's neurologist at Kaiser, wrote a letter stating that Wright's neurological disorder was producing a gait disorder, unsteadiness when walking, numbness in her hands, and that she suffered chronic neck and shoulder pain. Tr. 499. He opined that Wright was unable to work, could not use her hands for long periods and was too unsteady on her feet to perform jobs requiring walking or standing. *Id.*

Dr. Jones completed a medical source statement on October 9, 2004, noting that Wright was limited to a sedentary level of exertion, and could stand or walk for 15 minutes. Tr. 541-44. With breaks, she could stand or walk for three hours throughout an eight hour work day and could sit for one hour at a time for a total of three hours throughout an eight hour work day with breaks to lie down for 15 minutes every hour, or recline for 45 minutes. Tr. 541-42. He noted postural and manipulative limitations and extreme limitations in the ability to complete an eight-hour work day. Tr. 544. Dr. Jones wrote a letter on June 10, 2005, to the Oregon Public Employees Retirement System ("OPERS") stating that Wright had a gait disturbance, chronic back pain, vitamin B12 deficiency with residual posterior column dysfunction, and nerve studies showed sensorimotor axonal polyneuropathy. Tr. 567. He noted Dr. Gancher's finding of transmission problems through the cervical spinal cord, and agreed with Dr. Gancher that

Wright was too unsteady to perform jobs requiring walking or standing, and was unable to use her hands for long periods of time. *Id.*

Dr. Karen Dellinger, Wright's neurologist at OHSU, also wrote a letter to OPERS in June 2005 stating that Wright's gait disturbance and pain issues prevented her from working her past job. Tr. 566. She noted further that Wright could not use her hands for prolonged periods and could not do prolonged standing or walking. *Id.*

Some consulting physicians stated different views. Based on a consultative examination in January 2003, Dr. Jean W. Wyles, a physiatrist, concluded that Wright could have facet joint syndrome or lumbosacral strain in her quadratus lumborum. Tr. 631-33. However, Dr. Wyles thought it would be counterproductive to recommend disability as Wright was resistant to moving. Tr. 633. In July 2003, Dr. Nelson encouraged Wright to accept that there might not be a definitive diagnosis for her condition and if she persisted in requesting testing, she would lose credibility and be perceived as somaticizing. Tr. 714-18. Dr. Kathryn Chung, of the OHSU Movement Disorder Clinic, believed Wright had somatoform disorder and true hypochondriasis. Tr. 761. She felt it was necessary to move Wright toward rehabilitation and away from seeking the "answer" through more testing. *Id.*

In late 2004, Wright was referred to Dr. Jeffrey Brown, a neurologist at OHSU, to determine if she had a vestibular disorder. Tr. 560. Dr. Brown saw no signs of vestibulopathy and guessed that "she has somehow bruised the [spinal] cord or impinged on it in some way with some resulting edema at the time of her injury and now is experiencing intermittent transmission problems through the cervical cord." Tr. 562. Dr. Brown recommended a trial of central nervous system inhibitors, but noted the options could be limited to manipulation of the neck, by

wearing a collar, or inhibitory neurotransmitter substitution in order to get Wright to some type of functional activity. *Id.*

Wright underwent a series of vestibular tests in late 2005 at the Mayo Clinic spine center. Tr. 799-840. Doctors there diagnosed her with peripheral neuropathy, potential cerebellar deficits related to long-term anti-seizure medication, bilateral sensory neural hearing loss, gait disorder, chronic pain syndrome, and vestibular hypofunction, right side. Tr. 799, 805. They recommended facet joint injections based on a noted abnormality of the right quadratus lumborum muscle. Tr. 811.

In November 2005, Dr. Dellinger, her OHSU neurologist, noted the vestibular disorder diagnosed at the Mayo Clinic and referred her to Dr. Sean O. McMenomey. Tr. 841. Dr. McMenomey opined that a vestibular disorder could not cause all of her complaints and there was possibly some central nervous system pathology. Tr. 836.

Dr. Brown reviewed the testing results from the Mayo Clinic and examined Wright again in April 2006. Tr. 850-53. In a letter to Dr. Jones dated April 7, 2006, he noted that the Mayo Clinic vestibular testing indicated Wright has Class III vestibular impairment. Tr. 851. Dr. Brown stated: "In fact, of the three sensory systems for balance, including her visual, somatosensory, and her vestibular, she has compromise in two of the three." *Id.* He added that "the sensory conflict generated by all of her movements is producing a gait disturbance, a generalized hypersensitivity to motion and perception of motion when it is not present." *Id.* Dr. Brown noted further that her vitamin B12 deficiency may have affected posterior columns which produce a loss of joint position sense. *Id.* He further noted her small fiber sensorimotor distal axonal neuropathy and polyneuropathy. Tr. 850. Dr. Brown found it "difficult to

reconcile these abnormalities with her fall, although the description of her symptoms at the time of the fall was consistent with spinal cord contusion. This, I think, has resolved and what she is left with is a primary degenerative process affecting both the vestibular system and the somatosensory system." Tr. 851. Dr. Brown opined further that:

> The patient is disabled from working at heights, operating heavy machinery or from any work in a standing position. She is not going to be able to return to laboratory work as she is vision dependent for balance which would induce strong sensations of movement while looking through microscopes and motion sickness as a result. Although there are some activities in which she might find employment, her employability itself is highly challenged as she, from one day to the next, may be more or less symptomatic and unpredictable as a worker. She does have objective findings which taken in context of the whole of the balance system readily explain both her unusual lurching gait, sensory conflict symptoms and her vision dependence. Unfortunately, given the degenerative nature of this, they are likely to continue and become worsened over time.

Tr. 851-52.

On May 12, 2006, Dr. Brown wrote another letter to Dr. Jones, stating the cervical MRI scans from the Mayo Clinic show "spinal stenosis with remodeling and flattening of the spinal cord at C6-[C]7." Tr. 854. He noted: "Of all the issues related to her condition including vestibular dysfunction, posterior column disease and small fiber sensory neuropathy, a cervical myelopathy represents the only potentially treatable cause of some of her symptoms." *Id.* On October 13, 2006, Dr. Brown amended his initial October 21, 2004 evaluation regarding vestibulopathy, noting that the subsequent Mayo Clinic testing revealed "right peripheral vestibulopathy not evident by simple bedside testing." Tr. 7B. He further opined that Wright has cervical myelopathy and probable small fiber sensorimotor distal axonal neuropathy. *Id.*

II. Severe Impairments

Wright asserts the ALJ erred at step two of the sequential analysis by failing to find that her gait disorder, vestibular hypofunction, motor sensory neuropathy, history of seizure disorder, bilateral sensorineural hearing loss and vitamin B12 deficiency were severe, either singly or in combination. An impairment is severe if it significantly limits the ability to do basic work activities. These include physical functions, such as seeing, hearing, speaking, walking, standing and sitting, and mental functions, such as understanding, remembering, using judgment and responding appropriately to work situations. 20 CFR § 404.1521(b).

The ALJ found that Wright has severe impairments. Tr. 16. He was then required to continue the sequential analysis and consider the combined effect of all Wright's impairments, both severe and nonsevere. 20 CFR § 404.1523. Because step two was resolved in Wright's favor, any error made by the ALJ at step two is harmless. *Stout v. Comm'r, Soc. Sec. Admin.,* 454 F3d 1050, 1055 (9th Cir 2006), citing *Burch v. Barnhart*, 400 F3d 676, 682 (9th Cir 2005). The issue is whether the ALJ properly determined the functional limitations imposed by all of Wright's impairments in the remaining steps of the analysis.

III. RFC Determination

The ALJ determined Wright could work at a light level of exertion. He found she could stand, walk, and sit for six hours out of an eight hour day, with limitations in her ability to crouch, bend and climb stairs. As a result, the ALJ found Wright could perform her past relevant work as a medical technologist.

A. Physicians' Opinions

The Commissioner concedes the ALJ erred in evaluating the opinions of Drs. Brown, Gancher, Dellinger, and Jones regarding Wright's vestibular disorder and hand numbness.

Dr. Jones is Wright's primary care physician. Drs. Gancher and Dellinger are treating neurologists. Dr. Brown is an examining neurologist with special expertise in vestibular dysfunction. Social Security regulations specify that the most weight is given to the opinions of treating physicians, followed by examining physicians, with the least amount of weight given to nonexamining experts. *Holohan v. Massanari*, 246 F3d 1195, 1201-02 (9th Cir 2001). The ALJ can reject the opinion of a treating physician that is inconsistent with the opinions of other treating or examining physicians, if the ALJ makes findings setting forth "specific and legitimate reasons" based on substantial evidence in the record. *Lester v. Chater*, 81 F3d 821, 830 (9th Cir 1995). An uncontradicted opinion of a treating physician may be rejected only for clear and convincing reasons. *Thomas v. Barnhart,* 278 F3d 947, 957 (9th Cir 2002). In addition, the regulations give more weight to opinions of specialists regarding the area of their expertise. *Holohan*, 246 F3d at 1202; 20 CFR § 404.1527 (d)(5).

In his letter dated April 7, 2006, based on testing done at the Mayo Clinic and his recent examination, Dr. Brown revised his 2004 opinion regarding Wright's vestibular and other disorders. Tr. 850-53. He also opined regarding her functional limitations with respect to work. Tr. 851-52.

The ALJ did not mention Dr. Brown's April 7, 2006 letter in his decision. The Appeals Council, however, specifically considered that letter in its determination not to review the ALJ decision (Tr. 5), making it part of the record. The ALJ repeatedly asserted that Wright's vestibular dysfunction is either nonexistent or results in no functional limitations. Tr. 16-17, 20. To support his findings, the ALJ cited the testimony of Dr. DeBolt, the medical expert ("ME") who testified at the hearing. Tr. 20. Dr. DeBolt noted Dr. Brown's expertise and cited Dr.

Brown's 2004 evaluation. Tr. 922 ("Jeffrey Brown, here, who is really quite an expert in vestibular disorders saw her, did not find any problems."). When asked about the difference in findings between OHSU and the Mayo Clinic, Dr. DeBolt responded: "About the preponderance of the balance sensation in one ear. Jeffrey Brown here did not find that." Tr. 926. In making this response, Dr. DeBolt clearly relied on Dr. Brown's earlier reports and did not have access to Dr. Brown's more recent assessment.

Dr. Brown gives the most recent opinion in the medical record and it is based on the results of the extensive testing done at the Mayo Clinic and on his examination. As recognized by the ME testifying at the hearing, Dr. Brown is a neurologist with expertise in vestibular disorders. Regarding the Mayo Clinic diagnoses, the ALJ cited the opinion of Dr. McMenomey that all of Wright's complaints could not be attributed to a vestibular disorder. Tr. 20. However, Dr. McMenomey went on to state there was probably central nervous system pathology related to unsteadiness as she did not exhibit classic peripheral vertigo and that central etiology could not be excluded. Tr. 844-45. This opinion is not inconsistent with that of Dr. Brown. Dr. Brown specifically noted the overlay of her conditions of vestibular dysfunction, posterior column disease, fiber sensorimotor distal axonal neuropathy, and cervical myelopathy. Tr. 854. He explained that Wright "does have objective findings which taken in context of the whole of the balance system readily explain both her unusual lurching gait, sensory conflict symptoms and her vision dependence. Unfortunately, given the degenerative nature of this, they are likely to continue and become worsened over time." Tr. 852. Dr. Brown's opinion, based on the latest and most comprehensive examinations, is not controverted. As the Commissioner concedes, it was error to reject this opinion.

The Commissioner also concedes error regarding the evaluation of the opinions of Drs. Gancher, Dellinger, and Jones regarding Wright's hand numbness and vestibular disorder. Dr. Gancher, a treating neurologist form Kaiser, wrote a letter on January 21, 2004, stating Wright's neurological disorder was producing a gait disorder, unsteadiness when walking, numbness in her hands, chronic neck and shoulder pain, and depression and anxiety. Tr. 499. He noted she was unable to work, could not use her hands for long periods, and could not perform jobs requiring walking or standing. *Id.* Dr. Dellinger, a treating neurologist from OHSU, opined in June 2005 that Wright's gait disturbance prevented her from returning to her past laboratory work and that she was unable to use her hands for a prolonged period and was too unsteady on her feet for prolonged standing or walking. Tr. 566. Dr. Jones, Wright's primary care physician, also opined in June 2005 that Wright had a disabling condition involving gait disturbance and chronic back pain, and he noted the medical tests indicating residual posterior column dysfunction and sensorimotor axonal polyneuropathy. Tr. 567. Dr. Jones also concurred with Dr. Gancher that Wright was unable to perform jobs requiring walking, standing, or using her hands for long periods. *Id.* These treating physician opinions agree Wright is unable to do jobs requiring prolonged use of her hands or walking and standing. These improperly rejected opinions also support Dr. Brown's 2006 opinion.

B. <u>Credibility</u>

The ALJ must assess the credibility of the claimant regarding the severity of symptoms only if the claimant produces objective medical evidence of an underlying impairment that could reasonably be expected to produce the symptoms. *Smolen v. Chater*, 80 F3d 1273, 1281 (9th Cir 1996). Wright has medically determinable impairments which could produce her symptoms.

Given the existence of an underlying impairment and no evidence of malingering, the ALJ could discredit Wright's testimony regarding the severity of her symptoms only by providing clear and convincing reasons based on specific findings. *Dodrill v. Shalala*, 12 F3d 915, 918 (9th Cir 1993).

In assessing credibility, the ALJ may consider Wright's treatment history, including the effectiveness of medications, aggravating factors, and any unexplained failure to seek treatment. *Smolen,* 80 F3d at 1284-85. The ALJ found Wright's allegations of back pain credible in light of the treatment record and consistent with her RFC, but found her symptoms of weakness and gait disturbance not credible based on a lack of medical evidence. Tr. 19.

Wright testified at the hearing that she has trouble with balance and walking. Tr. 907. She also testified she had difficulty with "busy environments" which made her feel she needed to lay down. Tr. 908. She usually needs to lay down during the day and is unable to sit for more than four hours throughout the day. Tr. 901, 911. As noted above, Wright's unusual combination of neurological and vestibular conditions which produce these symptoms is well documented by Drs. Brown, Gancher, Dellinger, and Jones. However, the ALJ improperly discredited these opinions in his credibility determination. Tr. 23-24.

In support of his credibility finding, the ALJ cited the 2002 comment of Dr. Stacey, of the Pain Management Center, that Wright's choice to stay in bed due to weakness was volitional and not based on physical findings. Tr. 19. However, a week later, Wright was hospitalized for orthostatic hypotension secondary to Desipramine therapy, the medication prescribed by Dr. Stacey.

The ALJ also cited a March 2002, examination by Dr. Zarelli, stating he found no evidence of significant neurological problems. However, the March 2002 examination was actually performed by Dr. Zukowski, who found Wright's brain MRI showed some demyelinating processes which indicated a need for further work-up. Tr. 375. He noted most of her exam was normal but was concerned about her vitamin B12 level and poor vibratory and proprioceptive sense in her feet. Tr. 378. Dr. Zukowski also recommended flexeril instead of the tapering dosages of Desipramine. *Id.*

In further support of his opinion that the medical evidence did not support Wright's symptoms, the ALJ cited the comments of Dr. Wyles, a physiatrist who examined Wright in May 2002. Tr. 262-63. Dr. Wyles referred Wright to neurology and stated she would not take Wright off work but "was not following her." *Id.* She examined Wright again in January 2003 and opined that Wright could have facet joint syndrome, gave her a heel lift to change her gait, and noted she would not support a disability finding because Wright was resistant to moving. Tr. 632-34.

The ALJ also cited Dr. Chung, a one-time examining physician from the Movement Disorder Clinic, who believed Wright had somatoform disorder, and true hypochondriasis. Tr. 20. Dr. Chung noted despite her assurance everything was normal, Wright was unconvinced and stated that "she will continue to seek the 'answer.'" Tr. 761. Dr. Chung further noted: "She did not seem to be relieved that not having any physical abnormality represented a probably good outlook for her. In fact, she seemed downright disappointed that I could not find something abnormal. Either way, I encouraged her not to seek further diagnostic testing." *Id.*

Even if some of the medical evidence supported his determination, an ALJ cannot discredit a claimant's symptom testimony solely on the lack of medical evidence to support the degree of the symptoms. *Bunnell v. Sullivan,* 947 F2d 341, 343 (9th Cir 1991) (*en banc*). The ALJ should consider other factors, including the claimant's daily activities, work record, and the observations of physicians and third parties with personal knowledge about the claimant's functional limitations. *Thomas,* 278 F3d at 958-59. The ALJ did not address Wright's long work history, or the modifications Wright made to her work schedule to stay employed.

Although Wright's activities of daily living are very limited, the ALJ stated: "While the claimant may not prepare meals or do any household chores or lifting, there is no evidence that she is incapable of doing so." Tr. 22. In addressing lay witness testimony regarding observations of Wright's difficulties in balance, sitting and standing for any length of time, the ALJ found that while Wright "may sit or lie down after being out for an hour, there is no evidence that this is a medical necessity." *Id.*

In making these findings, the ALJ rejected the opinions of Wright's primary care physicians and treating neurologists regarding Wright's functional limitations. Tr. 23-24. Instead, the ALJ adopted the comments of physicians performing consultative examinations or made prior to Wright's neurological diagnoses. The ALJ should not search the record to find an inconsistency to support his finding and ignore all of the competent and substantial evidence that suggests the opposite conclusion. *Gallant v. Heckler*, 753 F2d 1450, 1456 (9th Cir 1984); *Holohan*, 246 F3d at 1205. The ALJ's credibility determination is based on his improper interpretation of the medical evidence and is insufficient. As a result, the ALJ failed to provide clear and convincing reasons for rejecting Wright's testimony.

IV. Remand

The decision whether to remand for further proceedings or for immediate payment of benefits is within the discretion of the court. *Harman v. Apfel*, 211 F3d 1172, 1178 (9th Cir 2000), *cert denied*, 531 US 1038 (2000). The issue turns on the utility of further proceedings. A remand for an award of benefits is appropriate when no useful purpose would be served by further administrative proceedings or when the record has been fully developed and the evidence is not sufficient to support the Commissioner's decision. *Rodriguez v. Bowen,* 876 F2d 759, 763 (9th Cir 1989).

The record in this matter is exhaustive. The most recent diagnostic evidence was accepted into the record by the Appeals Council. The Commissioner has conceded error in evaluation of pertinent medical evidence. The ALJ has improperly rejected Wright's testimony. Improperly rejected evidence should be credited and an immediate award of benefits directed where:

> (1) the ALJ has failed to provide legally sufficient reasons for rejecting such evidence, (2) there are no outstanding issues that must be resolved before a determination of disability can be made, and (3) it is clear from the record that the ALJ would be required to find the claimant disabled were such evidence credited.

Harman, 211 F3d at 1178 (citations omitted).

The improperly rejected medical evidence establishes Wright is unable to perform her past relevant work, or any work involving standing, walking, or prolonged use of her hands. In addition, Wright's employability is questioned due to daily fluctuations in her symptoms and her degenerative condition. Wright's improperly rejected testimony establishes she is unable to sit for more than four hours a day and frequently must lay down. Even a sedentary level of exertion

for work requires a certain amount of walking, standing, and prolonged sitting. 20 CFR § 404.1567. Crediting the improperly rejected evidence establishes that Wright is disabled within the meaning of the Social Security Act.

///

RECOMMENDATION

For the reasons set forth above, the Commissioner's Motion to Remand Case to Agency (docket #24) should be DENIED and the Commissioner's final decision should be REVERSED AND REMANDED for an immediate award of benefits. A final judgment should be entered pursuant to sentence four of 42 USC § 405(g).

SCHEDULING ORDER

Objections to the Findings and Recommendation, if any, are due April 14, 2008. If no objections are filed, then the Findings and Recommendation will be referred to a district judge and go under advisement on that date.

If objections are filed, then a response is due within 10 days after being served with a copy of the objections. When the response is due or filed, whichever date is earlier, the Findings and Recommendation will be referred to a district judge and go under advisement.

DATED this 4th day of April, 2008.

/s/ Janice M. Stewart_____
Janice M. Stewart
United States Magistrate Judge